OLR RESEARCH REPORT

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CBIA HEALTH CONNECTIONS PROGRAMS

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You asked for a description of the Connecticut Business and Industry Association's (CBIA) Health Connections programs. Specifically, you wanted to know which insurers participate in these programs, what type of employers participate, and whether insurance plans offered are arranged by "metal groups" comparable to the groupings mandated under the federal Patient Protection and Affordable Care Act (PPACA, P.L. 111-148).

SUMMARY

CBIA administers two Health Connections programs, one for employers with three to 50 employees and another for employers with 51 to 100 employees. Both programs offer a variety of plans provided by ConnectiCare and Oxford. The plans offer a wide range of options regarding deductibles for hospitalization, other services, and the plan as a whole; co-insurance requirements; and charges for individual services.

Premiums for the plans are set using adjusted community rating, as required by state law (CGS § 38a-567(5)(A)). This approach prohibits insurers from setting premiums based on health factors. It requires a base rate (community rate) that is adjusted for key, permissible characteristics, such as age. Under PPACA, starting in 2014 premiums will be allowed to vary based only on family composition, location, age, and tobacco use.

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According to CBIA staff, approximately 5,000 to 6,000 employers participate in the programs, with about 40,000 employees. The average participating employer has fewer than 10 employees. The employers are spread throughout the state and include a wide variety of small employers. Participation in the programs has been relatively stable, although it has declined somewhat in recent years, in part due to the recession. Further information about the programs is available at http://www.cbia.com/ieb/er/medical/hc2/default.htm.

PPACA requires individuals, with some exceptions, to maintain health insurance beginning in 2014. Individuals will be required to maintain minimum essential coverage. Coverage provided for the essential health benefits package will provide bronze, silver, gold, or platinum level of coverage. A plan's "metal" rating is based on the generosity of its benefits. (OLR Report 2010-R-0255 describes the provisions of PPACA that affect private health insurance.)

There is insufficient information at this time to determine how the plans offered under CBIA's programs, or other insurance plans, would be categorized under PPACA's provisions regarding minimum essential coverage. Before this can happen, the state will need to specify the specific services included in essential health benefits package and determine the generosity of individual plans in providing benefits for these services.

CBIA HEALTH CONNECTIONS PROGRAM

CBIA established the precursor to the Health Connections programs in 1995. Currently, CBIA offers two programs, Health Connections 2 for employers with three to 50 employees and Health Connections 51+ those with 51 to 100 employees. Employees who participate in either program can choose ConnectiCare or Oxford as their insurer. CBIA sets the programs' rules and administers billing, among other functions.

The Health Connections 2 program offers 12 plans using the point of service (POS) and health maintenance organization (HMO) models. All of the plans offer a wide range of benefits, with varying levels of coverage. The benefits each insurer offers under a specific plan are identical on their key features (e.g., plan deductibles and charges for office visits). None of the plans have a lifetime maximum benefit. There are parallel plans under Health Connections 51+.

However, there are some differences in specific benefits between the two insurers. For example, while both insurers fully cover routine physical examinations (including immunizations), ConnectiCare covers one exam annually while Oxford does not have a schedule for routine physicals, instead requiring the primary care physician (PCP) to be guided by good medical practice and individual circumstances. On the other hand, Connecticare covers up to 90 days per contract year for skilled nursing facility care. Oxford covers up to 60 days per calendar year. For both insurers, this benefit applies when authorized and is subject to applicable hospital co-pay and deductibles.

Table 1 presents an overview of inpatient hospital and outpatient surgery benefits for in-network services under the Health Connections 2 plans. The plan name indicates whether it uses the HMO or POS model, the charge for an office visit for a PCP and specialist and, where applicable, the plan deductible for an individual and co-insurance percentage (e.g., POS $30/45-$2,5000-20%). The parameters are similar under the Health Connections 51+ plans. (Both programs have different benefits for out of network services.)

Most of the plans do not have co-insurance requirements. But the "POS $30/45-$2,500 -20%" plan has a 20% co-insurance provision while the "POS $30/45-$2,500 -30%" plan requires 30% co-insurance. The former plan limits total annual out-of-pocket expenses for (1) co-insurance for health services and (2) the plan deductible to $5,000 per year for individuals and $10,000 for families. For the latter plan, the out-of-pocket maximum is $5,850 for individuals and $11,700 for families.

For most of the plans, the charge for an office visit is $30 for a PCP and $45 for a specialist. However, for the "POS $20/$40 - $1500" and "POS $20/$40 - $2500", these charges are $20 and $40, respectively. For the "POS $20 and $20 OA" plan, the office visit charge is $20 for all physicians. For the "POS $30-$2,000/30%", the charge for a PCP is $30; for a visit to a specialist there is a 30% co-pay after the deductible.

Table 1: In-Network Benefit Summary of Health Connections 2 Plans

Plan name/ Model	***Plan Deductible (individual/ family)***	***Hospital Inpatient***	***Outpatient Surgery***
HMO $30/45	Not applicable (n.a.)	Covered in full after $500 per day co-pay to a maximum of $2,000 per year	$30 PCP office; $45 specialist office; $500 outpatient facility
HMO $30/45-$2,500	$2,500/ $5,000	Subject to plan deductible, then covered in full	$30 PCP office; $45 specialist office; outpatient facility—covered in full after plan deductible
HMO $20	n.a.	Covered in full after $500 per admission co-pay	$20 doctor's office; $100 outpatient facility
POS $30/45	n.a.	Covered in full after $500 per day co-pay to a maximum of $2,000 per year	$30 PCP office; $45 specialist office; $500 outpatient facility
POS $30/45-$5,000	n.a.	Covered in full after hospital & facility-based services deductible of $5,000 individual/ $10,000 family	$30 PCP office; $45 specialist office; outpatient facility: subject to the hospital & facility-based services deductible
POS $30/45-$3,000	n.a.	Covered in full after hospital & facility-based services deductible of $3,000 individual/ $6,000 family	$30 PCP office; $45 specialist office; outpatient facility: subject to the hospital & facility-based services deductible
POS $30/45-$2,500 - 20%	$2,500 individual/ $5,000 family	Covered at 80% after deductible	$30 PCP office; $45 specialist office; outpatient facility: subject to deductible then 20% coinsurance
POS $30/45-$2,850 - 30%	$2,850 individual/ $5,700 family	Covered at 70% after deductible	$30 PCP office; $45 specialist office; outpatient facility: subject to deductible then 30% coinsurance
POS $20/40-$1,500	n.a.	Covered in full after hospital & facility-based services deductible of $1,500 individual/ $3,000 family	$20 PCP office; $40 specialist office; outpatient facility: subject to the hospital & facility-based services Deductible
POS $20/40-$2,500	n.a.	Covered in full after hospital & facility-based services deductible of $2,500 individual/ $5,000 family	$20 PCP office; $40 specialist office; outpatient facility: subject to the hospital & facility-based services deductible
POS $20 and $20 OA	n.a.	Covered in full after $500 per admission co-pay	$20 doctor's office $100 outpatient facility

Source: http://www.cbia.com/ieb/er/medical/hc2/default.htm.

RELATIONSHIP TO "METAL GROUPS"

PPACA requires individuals, with some exceptions, to maintain health insurance beginning in 2014. Individuals will be required to maintain minimum essential coverage, which can be obtained through eligible employer coverage, individual coverage, and federal programs such as Medicare and Medicaid, among others.

PPACA defines "essential health benefits" as:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care (§ 1302(b)).

For a discussion of essential health benefits, see OLR Report 2012-R-0022.

Coverage provided for the essential health benefits package will be categorized as bronze, silver, gold, or platinum. A plan's metal tier is based on the actuarial value of its benefits. The actuarial value is a summary measure of a health plan's benefit generosity. It is expressed as the percentage of medical expenses that the insurer would pay for a standard population and set of allowed charges. The percentage is 60% for bronze plans, 70% for silver plans, 80% for gold plans, and 90% for platinum plans.

While CBIA's Health Connections programs offer a wide range of benefit levels, there is insufficient information at this time to determine how the plans offered under them, or other insurance plans, would be categorized under PPACA's "metal groups." The federal government has transferred to the states the responsibility to determine what specific services will be included in the essential health benefits. Once this is determined, the percentage of medical expenses that the insurer would pay for a standard population and set of allowed charges will need to be estimated in order to determine how an individual plan would be categorized.

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